Study on perception on HIV infection and prevention among religious leaders of Presbyterian Church, Aizawl, Mizoram

Lalchhanhima Ralte, MBBS, MPH

Sree Chitra Tirunal Institute for Medical Sciences and Technology

Srinivasan Kannan PhD (✉ kannansrini@ymail.com)

Sree Chitra Tirunal Institute for Medical Sciences and Technology <https://orcid.org/0000-0003-2731-9428>

Research Article

Keywords: Bible, Christianity, Church leaders, Condom, HIV, Mizoram, Presbyterian Church, Syringe

Posted Date: September 10th, 2021

DOI: <https://doi.org/10.21203/rs.3.rs-888984/v1>

License: © ⓘ This work is licensed under a Creative Commons Attribution 4.0 International License. [Read Full License](#)

Abstract

Aim of the study is to find the perceptions of Presbyterian Church leaders about HIV prevention in Aizawl, Mizoram. For the study, mixed method was followed for data collection. From 15 Presbyterian churches, 293 Church leaders representing four groups, that is, Pastor/Elder, Women, Youth and Men were randomly selected and used self-administered questionnaire for the purpose of understanding perceptions on HIV prevention from them. Chi-square test was done to understand the associations with different factors. Qualitative information was collected using in-depth interviews from 12 and focus group discussions from 3 leaders. Thirty four percent of leaders expressed willingness to advocate condom for prevention. Majority (97.3 %) of leaders felt they need to intervene and 90% were for including HIV prevention in church services. Two third (70 %) felt Biblical disobedience causes HIV and 80% felt homosexuals deserved it. Leaders preferred abstinence, marital fidelity, and condom use as appropriate methods for HIV prevention. About 70% agreed with the Church statement, 'condoms encourage pre-marital sex', and above 80% reported condom prevents HIV. Analysis show, contacting person living with HIV (PLHIV) was not positively associated with willingness to advocate condom use. Church leaders their inability quoting the church doctrine as constraint. Many felt disobedience to Biblical teachings and sinful acts result in HIV. Leaders felt, educating church leaders and disseminating sex education using church media were effective methods for HIV prevention.

Introduction

Acquired Immune Deficiency Syndrome (AIDS) (CDC, 2011) emerged in the early 1980s. In India, HIV was first detected in 1986 among commercial sex workers in Madras (Now Chennai) (Simoes et al., 1987). UNAIDS 'Gap Report'(2014) estimated India has the third highest number of people living with HIV after Nigeria and South Africa and accounts for 4 out of 10 people living with HIV in the Asia Pacific region. According to National AIDS Control Organisation (NACO) Annual Report 2015–2016, the overall HIV prevalence among ANC clinic attendees, considered to be a representative of the general population continues to be at 0.26%. The adult HIV prevalence has continued its decline from a peak of 0.38% in 2001-03 through 0.34% in 2007 and 0.28% in 2012 to 0.26% in 2015. However, the total number of people living with HIV in India is estimated at 2.1 Million in 2015. Children below 15 years account for 6.54%, while 40.5% are females. India is estimated to have about 86,000 new infections during 2015, showing a 66% decline in new infections from 2000 and 32% decline from 2007 (NACO, 2016). Again children less than 15 years accounted for 12% of total new infections. AIDS-related death has shown a declining trend since 2007. Around 67,000 people died of AIDS-related deaths in 2014 (NACO, 2014). Mizoram has the second highest estimated adult HIV prevalence at 0.80% in India (NACO, 2014). The first HIV case was detected in 1990 in an intravenous drug user. Since then, there are approximately 11,001 HIV infected individuals till December 2015 from October 1990 (MSACS, 2016). The main mode of transmission in the state is through sexual route which accounts for about 69.28% followed by intravenous drug users at 24.57% and mother to child at 3.60%. Study findings revealed that 94.5% of women and 96.3% of men between the age group 15 to 49 have heard of HIV/AIDS (MSACS, 2016).

Condom use in a Christian context is considered a sin or promoting sin, according to Christian leaders (Rankin et al., 2008). Faith leaders' hesitation to advocate condom for HIV prevention, because this might encourage young people to experiment with sex and will increase infidelity among married couples.

A study from Madagascar found that about 40 percent of the Church leaders were willing to advocate condom for HIV prevention. It also showed about 22 percent have undergone HIV testing while 4 percent had cared for people living with HIV (PLHIV). Brazilian National AIDS Program is globally known to be the leading example of an integrated HIV/AIDS prevention, care, and treatment program in a developing nation. Different sectors such as NGOs, government, media and PLHIV taken responsibility against HIV as a team, b agreeing the epidemic belonged to everyone, not just the high risk groups (Berkman et al., 2005).

Methods

A cross-sectional survey, focus group discussions and in-depth interviews were conducted.

Study setting

Study among the church leaders was conducted in the Presbyterian Church, Aizawl, Mizoram. According to 2011 census, 89 percent of Mizoram population were Christians. On that Presbyterian Church constitutes 51 percent and the Baptist about 16 percent. Most of the Presbyterian Church leaders live in and around the Aizawl city.

Sample size

The sample size was calculated using Open Epi version 3.0.1, after considering the proportion of Church leaders recommend condom as prevention for HIV. A study on the attitudes of Christian religious leaders in Madagascar (2013) among 231 leaders found 39.4 percent of the leaders recommended condom as prevention for HIV. Keeping this in background with 95 percent confidence interval, with 7 percent precision and design effect 1.5, the sample size was estimated to 265 and rounded to 300 considering 10 percent non-response rate.

Sample Selection

Following cluster sampling, from the all 151 Presbyterian churches in Aizawl city, 15 with all 4 sets of leaders include, elders and pastors, women, youth and men fellowship were randomly selected. List of churches was obtained from the Synod book 2015 (Annual publication of Mizoram Presbyterian Church). From each of the randomly selected churches, five leaders from each of the group, a total of twenty leaders in each church, were given the self-administered questionnaire. From the selected 15 Churches, 75 pastors/elders, 75 women leaders, 75 youth leaders and 75 men leaders were included (Fig. 1).

Focus group discussions (FGD) among church leaders, participants were purposively selected from the churches for each of the four leadership groups. Three FGDs and twelve in-depth interviews were conducted. Two leaders from each group of church leaders identified during the FGDs were included for in-depth interviews. In addition, head and the leader of the youth fellowship of the Mizoram Presbyterian church were also interviewed.

Data Collection

A self-administered questionnaire based on literature was first developed in English, then translated into Mizo, and later back-translated to English by a person who knew both languages. The sections in the questionnaire include, background information, HIV prevention-related responsibilities, opinion on condom use, association between Bible and sexuality, and personal relationship with people living with HIV. In-depth interview and focus group discussion guidelines were developed separately on the same lines.

Data Analysis

Quantitative data were analysed using SPSS (version 21) software. Frequencies and means generated for description, Pearson's Chi-Square test and Fisher's exact test were performed to study the association between willing to advocate condom use, willing to advocate needle syringe exchange program and leadership position in Church with other variables.

Transcripts of in-depth interviews and focus group discussions were translated to English. Field notes, audio recordings and translated transcripts were thoroughly studied, and codes were assigned deductively to different broader categories manually.

Ethical Clearance

Informed consent form for questionnaires, in-depth interview and focus group discussion were developed in Mizo and English. Ethics clearance was obtained from the Institutional Ethics Committee of Sree Chitra Tirunal Institute for Medical Sciences and Technology (Reference number: SCT/IEC/911/MAY-2016).

Results

There were 293 Presbyterian Church leaders from 15 Churches of Aizawl, Mizoram (Table 1). There were 75 respondents each representing three groups – Pastor/Elders (*Upa*), Women (*Kohhran Hmeichhia*), and Youth (*KTP*), 68 among the Men's group (*Kohhran Pavalai Pawl*). In men's group there were 7 respondents who have not responded as they were neither interested nor had time to participate. About two-thirds of the respondents have been church leaders for more than 5 years. The mean ages of the respondents are shown in Table 1.

Table 1 Leadership characteristics of the Church leaders (N = 293)		
Type	N (%)	Mean age in years (SD)
Leadership position	293(100)	50.77 (12)
Pastor/Elder	75 (25.6)	58.19 (11.50)
Women group	75 (25.6)	58.55 (5.48)
Youth group	75 (25.6)	35.25 (3.05)
Men group	68 (23.2)	51.12 (6.26)
Duration in current position N (%)		
Less than 1 year	21 (7.2)	
Between 1–5 years	88 (30)	
More than 5 years	184 (62.8)	

Only 27.3% of Church leaders were women. More than half of the Church leaders had either graduation or postgraduate degrees, while only 2.7% had theology qualification. More than half of the Church leaders were currently employed in government jobs. More than 40% earned between Rs.10, 000–30,000 per month (Please refer Table 2).

Table 2
Church leaders characteristic N = 293

Characteristics	N (%)
Sex	
Male	213 (72.7)
Female	80 (27.3)
Marital status	
Single	37 (12.6)
Married	245 (83.6)
Widow/Widower	11 (3.8)
Education	
HSS or lower	120 (41)
Graduate/PG	165 (56.3)
Theological	8 (2.7)
Occupation	
Homemaker	25 (8.5)
Student	3 (1)
Self – employed	88 (30)
Govt. Employed	151 (51.5)
Pensioner	24 (8.2)
Pastor	2 (0.7)
Monthly Income	
< Rs.10, 000	30 (10.2)
Rs.10, 000 – Rs. 30,000	120 (41)
Rs.30, 000 – Rs. 50,000	79 (27)
Rs. 50,000 <=	64 (21.8)

Table 3 shows most of the Church leaders except some genuinely felt HIV prevention topics must be discussed during Church services. Most of the leaders agreed they should talk about HIV during Church services. Only 68% shared about HIV among youth of the Church. Only about one third felt Church was sufficiently engaged in HIV prevention. Church leaders emphasized sexual abstinence before marriage for HIV prevention, followed by being faithful or marital fidelity. All except three were willing to share about HIV/AIDS among Church members. Those unwilling stated it is highly inappropriate to share, and anticipated opposition from other leaders. Only 30 percent of the leaders were willing to advocate condom use. The reasons for non-advocating condom were, it may increase sexual promiscuity (41%), condoms were not fully effective (28%), it was against Biblical teaching (28%) and they were not comfortable advocating it (4%).

Table 3
Opinion on responsibility of Church leaders on HIV prevention (N = 293)

Opinions	N (%)
Church leaders should be concerned and intervene in HIV prevention.	285 (97.3)
Church leaders should talk about HIV issues in Church services	265 (90.4)
Church leaders should talk about HIV issues like condom/syringe among youth	199 (67.9)
Church doing enough work on HIV prevention	88 (30)
For prevention, the Church should stress mostly on	
Sexual abstinence before marriage	226 (77.1)
Being faithful/marital fidelity	65 (22.2)
Condom use	1 (0.3)
Others	1 (0.3)
Willing to share knowledge of HIV AIDS in Church services.	290 (99)
If unwilling, the reasons	
Opposition from other Church leaders	3 (100)
Willing to advocate condom use for HIV prevention	89 (30.4)
If unwilling, the reasons	
Against the Bible	56 (27.5)
The condom is not 100% effective	57 (28.0)
Can lead to more sexual promiscuity	83 (40.7)
Not comfortable	8 (3.8)

Table 4 shows about two third of the leaders agreed with the church statement 'condoms encourage pre-marital sex'. While, more than 80 percent felt that condom prevents HIV infection. More than 90% felt unprotected sex risks persons contracting HIV. Two third of Church leaders felt that Church should support NSEP. This is higher than willing to advocate condom use (30.4%). The reasons against NSEP were, it is not Biblical, it does not reduce HIV and it is not just right.

Table 4
Condom use and NSEP N = 293

Opinions	N (%)
Agree with Church statement that 'condoms encourage premarital sex	196 (66.9)
Agree that condom prevents spread of HIV infection	243 (82.9)
Unprotected sexual intercourse puts one at risk of contracting HIV	271 (92.5)
Church should support NSEP to reduce HIV transmission	191 (65.2)
Reasons for Church should not support NSEP	
i. Does not really reduce HIV	35 (11.9)
ii. Just not right	19 (6.48)
iii. Not Biblical	48 (16.38)

Table 5 shows about 67 percent of the leaders felt disobedience towards Biblical teachings can cause HIV infection; while only 32 percent agreed HIV is a punishment from God. More than three fourth of the leaders felt homosexuals deserved HIV. All except a few of felt babies/children don't deserve HIV infection.

Table 5
Opinions on Bible and Sexuality/HIV

Opinions	N = 293 (%)
According to the Bible, HIV is a punishment from God	94(32.1)
Disobedience to Biblical teaching cause HIV infection	196 (66.9)
Homosexuals deserve HIV infection	226 (77.1)
Babies/Children deserve HIV infection	11(3.8)

Personal involvement with PLHIV (People living with HIV)

Table 6 shows, about one third of Church leaders know a person with HIV within or outside the Church. About 10 percent of Church leaders reported, Church members/non-members disclosed their HIV status. More than one fourth use their position to educate members on HIV prevention.

Table 6
Personal involvement with PLHIV (N = 293)

Characteristics	N (%)
Personal contact or know anyone who is HIV positive.	97 (33.1)
A Church member who is PLHIV has disclosed his/her status to leader	28 (9.6)
Ever used your position in Church as a medium to educate Church members on HIV prevention issues	86 (29.4)
Willing to care for a sick relative/Church member and who is PLHIV	269 (91.8)
Willing to care for a stranger, who is PLHIV	141 (48.1)
If 'willing to care', what are the reasons?	N = 141
Compassion/moral duty	67 (47.5)
To decrease HIV transmission	10 (7.1)
It is Biblical	64 (45.4)
If 'not willing to care', what are the reasons?	N = 152
Uncomfortable	87 (57.2)
Afraid	39 (25.6)
Do not feel like helping	24 (15.8)
Not Biblical	2 (1.4)

Majority of Church leaders expressed their willingness to care a sick HIV person. However, more than half were not willing to take care of a stranger. Among those willing to take care of strangers the reasons stated were, compassion/moral duty, Biblical and to reduce HIV transmission. While those who were unwilling stated the following, uncomfortable, afraid, didn't feel like helping and non-Biblical.

Church Activities

It is interesting to note many Church leaders were willing to share communion cups or other items with a person living with HIV part of Church activities (Table 7). While only 29% were comfortable sitting with a person living with HIV on a Church bench. Very few were comfortable sharing restrooms/toilets with PLHIV.

Table 7
Church activities (N = 293)

Characteristics	N (%)
Comfortable sharing communion cups or other items with PLHIV	211 (72)
Comfortable sitting together on a Church bench with PLHIV	84(28.7)
Comfortable sharing restrooms/toilets with PLHIV	23 (7.8)

Table 8 shows, 77% of Church leaders felt that talking more on HIV prevention strategies would definitely improve the situation. Only 30% of the Church leaders were of the opinion that talks on HIV prevention may result in sexual debut and increase in experimenting with sex among young people.

Table 8
Consequences of HIV prevention

Variable	N = 293 (%)
More talk on HIV prevention would improve the situation	227 (77.5)
More talk on HIV prevention may result in early sexual debut and increase in experimentation among young people	90 (30.7)

Analysis based on position of Church leadership

About 75% of the men leaders felt that condoms and syringes should be discussed among young members of the Church, followed by the women and youth groups. Only 60% of the Pastors/Elders agreed to it. With regard to preferred choice of prevention strategy, abstinence was preferred by all four groups. Interestingly 85% youth leaders supported that. When it comes to 'condom encourages pre-marital sex', 80% of older leaders (Pastors/Elder/Women), 60% of men and youth leaders supported it. Only 61% of the youth leaders and about 70% of all other groups believed that Biblical disobedience leads to HIV.

Only about 38% of women leaders, 30% of Pastors/Elders, 26% of men and 14% of youth leaders were willing to sit with an HIV infected in church. On helping a stranger with HIV, 59% of youth leaders, 50% of Pastors/Elders, 50% of men and 29% of women leaders expressed willingness.

Bivariate analysis with Willingness to advocate condom use and socio-demographic factors

Bivariate analysis was done for the outcome variable-the willingness to advocate condom use with socio-demographic factors (Table 9). First Chi-square test was performed. If any cell value found to be less than 5, Fisher's exact test was done. The alpha value for significance was fixed at 5 percent (p-value < 0.05). There was only a slight variation within age groups and marital status. Otherwise no statistically significant association was found. Occupation was re-organized into 'remunerated' (self employed, govt employed, pastor, pensioner) and non-remunerated (student, housewife).

Variable	Category	Advocate condom use		Total N(%)	Chi-sq P value
		Yes	No		
Age	< 40 yrs	28 (33.3)	56 (66.7)	84 (100)	0.422
	41-60yrs	42 (27.1)	113 (72.9)	155 (100)	
	> 61 yrs	19 (35.2)	35 (64.8)	54 (100)	
Sex	Male	66 (31.0)	147 (69.0)	213 (100)	0.711
	Female	23 (28.8)	57 (71.3)	80 (100)	
Education level	HSS	36 (30.0)	84 (70.0)	120 (100)	0.807
	Graduate/ PG	49 (29.7)	116 (70.3)	165 (100)	
	Theological	4 (50.0)	4 (50.0)	8 (100)	
Occupation	Remunerated	69 (28.9)	170 (71.1)	239 (100)	0.239
	Non remunerated	20 (37.0)	34 (63.0)	54 (100)	
Monthly income	<Rs.30,000	46 (30.7)	104 (69.3)	150 (100)	0.912
	>Rs.30,000	43 (30.1)	100 (69.9)	143 (100)	
Marital status	Single	15 (40.5)	22 (59.5)	37 (100)	0.299
	Married	72 (29.4)	173 (70.6)	245 (100)	
	Widow/Widower	2 (18.2)	9(81.8)	11 (100)	

Bivariate analysis with Willingness to advocate condom use as the outcome variable.

Further, a bivariate analysis was done for willingness to advocate condom use as the outcome variable (Table 10). It was found that Church leaders who felt Church should support NSEP has positively associated with willingness to advocate condom. Among those who felt condom encourage pre-marital sex, there was a significant reduction in willingness to advocate condom. Similarly, those who agreed 'HIV is a punishment from God' influenced advocating condom use. Willingness to advocate condom use is also significantly influenced by Church leader's belief whether it saves lives and prevents HIV.

Table 10
Willingness to advocate condom use and associated factors

Variable	Category	Advocate condom use		Total N (%)	Chi-sq P value
		Yes	No		
Church should support NSEP	Yes	78 (40.8)	113 (59.2)	191 (100)	< 0.05
	No	11 (10.8)	91 (89.2)	102 (100)	
Use to share HIV in Church programs	Yes	27 (31.4)	59 (68.6)	86 (100)	0.807
	No	62 (30.0)	145 (70.0)	207 (100)	
Condom encourage pre – marital sex	Yes	39 (19.9)	157 (80.1)	196 (100)	< 0.05
	No	60 (51.5)	47 (48.5)	97 (100)	
Biblical disobedience leads to HIV	Yes	56 (28.6)	140 (71.4)	196 (100)	0.340
	No	33 (34.0)	64 (66.0)	97 (100)	
Leadership position in the Church	Pastor/Elder	19 (25.3)	56 (74.7)	75 (100)	0.378
	Women	21 (28.0)	54 (72.0)	75 (100)	
	Youth	23 (30.7)	52 (69.3)	75 (100)	
	Men	26 (38.2)	42 (61.8)	68 (100)	
Duration of leadership position in the Church	< 1 year	8 (38.1)	13 (61.9)	21 (100)	0.640
	1–5 years	28(31.8)	60(68.2)	88 (100)	
	> 5 years	53 (28.8)	131(71.2)	184 (100)	
Know any PLHIV with good acquaintance	Yes	32 (33.0)	65 (67.0)	97 (100)	0.494
	No	57 (29.1)	139 (70.9)	196 (100)	
The church member has disclosed HIV status to me	Yes	6 (21.4)	22 (78.6)	28 (100)	0.279
	No	83 (31.3)	182 (68.7)	265 (100)	
HIV is a punishment from God	Yes	21 (22.3)	73 (77.7)	94 (100)	< 0.05
	No	68 (34.2)	131 (65.8)	199 (100)	
Condom prevents HIV and save lives	Yes	86 (35.4)	157 (64.6)	243 (100)	< 0.05
	No	3 (6.0)	47 (94.0)	50 (100)	
Unprotected sex is easy way of getting HIV	Yes	85 (31.4)	186 (68.6)	271 (100)	0.235
	No	4 (18.2)	18 (81.8)	22 (100)	
More talk would improve HIV situation	Yes	70 (30.8)	157 (69.2)	227 (100)	0.750
	No	19 (28.8)	47 (71.2)	66 (100)	

Bivariate analysis with leadership position as the outcome variable

Table 11 shows, leadership positions and other variables. The following three tables show associations that are highly significant.

Table 11
Leadership position in Church and associated factors

Leadership position in Church and associated factors				Total N(%)	Chi-sq P value
Position in Church used to share HIV prevention issues		Yes	No		
Leadership position in the Church	Pastor/ Elder	33 (44.0)	42 (56.0)	75 (100)	< 0.05
	Women	26 (34.7)	49 (65.3)	75 (100)	
	Youth	18 (24.0)	57 (76.0)	75 (100)	
	Men	9 (13.2)	59 (86.8)	68 (100)	
Church doing enough on HIV prevention					
Leadership position in the Church	Pastor/ Elder	16 (21.3)	59 (78.7)	75 (100)	< 0.05
	Women	20 (26.7)	55 (73.3)	75 (100)	
	Youth	34 (45.3)	41 (54.7)	75 (100)	
	Men	18 (26.5)	50 (73.5)	68 (100)	
Church member has disclosed HIV status					
Leadership position in the Church	Pastor/ Elder	13 (17.3)	62 (82.7)	75 (100)	< 0.05
	Women	8 (10.7)	67 (89.3)	75 (100)	
	Youth	4 (5.3)	71 (94.7)	75 (100)	
	Men	3 (4.4)	65 (95.6)	68 (100)	

The first part of the Table 11 shows that Pastors/Elders used their position the most to share about HIV related issues in the Church. They are followed by the women, youth and men group. The second part of the Table 11 shows how nearly 80 percent of all the three groups except the youth group at around 55 percent felt that the Church is not doing enough towards HIV prevention. The third part of the Table 11 shows how Church members have preferences when it comes to disclosing their HIV status. They preferred Pastors/Elders, followed by women, youth and men.

Qualitative analysis on Church leaders' perception on HIV prevention

Three FGDs conducted among Men group (1) with 10 members, youth group(1) with 12 members, and women group(1) with 7 members to understand perceptions of Church leaders on HIV prevention. All were office bearers in addition to executive committee member of selected churches. Twelve in-depth interviews comprised of representatives of women group(3) hold top positions in the age group of 37–65 years, males representing pastors/elders(3) from Presbyterian churches in age group 45–70, males representing youth leaders(3) in the age group of 21–35, and males representing youth leaders(3) of Presbyterian churches, Aizawl in the age group 41–55.

Church and HIV prevention

'Christianity and HIV' was acknowledged swiftly with 'compassion' by most leaders. This indicates empathy of church leaders towards PLHIV. Youth leaders described this as 'an immense sense of a need to help them'. The deep-rooted Christian values with love and compassion drove that. A sense of duty and responsibility for spiritual and psychological needs of PLHIV was felt. Women leaders felt it was difficult to address the physical and medical needs of PLHIV. But Church has a role on it. Further leaders felt, PLHIV should not be viewed as 'sinners'. Among the affected only some require assistance. It is important that someone be available around them and listening or sitting with PLHIV in times of need will reduce depression and suicide tendencies. It was strongly felt by many that the negative perception on HIV emerged from the campaigns during 1990's on the target populations. In spite of its negative image, in general members of Presbyterian Church expressed their willingness to contribute to HIV prevention in Mizoram, a Christian dominant state. Some had hesitation by saying NGOs recommend condom and syringe that was against Christian belief. Youth and men suggested HIV infected should come forward and share their status with the community/Church. That would help in discussions by Church leaders on prevention, stigma and discrimination. Knowledge on HIV infection data in Church jurisdiction will help in prevention and Church would view it as a moral duty to serve them at all stages either directly or through NGOs. Core church leaders shown least interest led to poor interest on prevention and lacked an integration of church and HIV prevention. While, the training institutes of the Church, Aizawl Theological College and other Mizoram Presbyterian Church institutions have included HIV basics in their programs. There were also fears that HIV will adversely affect Mizoram.

Views on HIV as a punishment from God

Church leaders believed HIV, not a punishment by God, but stated persons committing 'Sins' will be infected by HIV. Women leaders disagreed with this as a punishment by God, and mentioned if it would include all diseases. Youth were of a similar opinion stating nobody could interpret God and it was insensitive for Church leaders comment like this. Some still believed it was a punishment. According to a leader, HIV infection interpreted as an instrument to get closer to God by explaining, "They must have done something bad", and "To repent for some sin?".

HIV prevention in Church services

The general perception was that any activity in Church had to be confirming with the Bible or Christian doctrines. The Pulpit the space where preachers preach is sacred and holy place, where Bible-related things are only allowed was the reason for leaders not supporting HIV prevention involving sex and sexuality. Many of them felt a sense of fear and apprehension to talk about HIV in Church and they were uneasy to discuss sex as they were of the opinion that it could increase sexual activity among youth and preferred talking to specific groups such as, commercial sex workers and intravenous drug users. Women leaders felt Church elders did not talk about HIV in Church due to discomfort. This is important as only elders make church decisions. General feeling among the community as well as the church was all live normal life have no infections. This denial was the reason for unwillingness to share HIV prevention in Church and lack of interest among congregants said a youth leader. The Church Elders could overcome the hesitation in talking about HIV after attending awareness programs and interacting with infected.

HIV Prevention Strategies

Leaders in general did not prefer advocating condom and syringe programs. However, some felt needle syringe exchange program was easy because it was about one person and there was no mention in Bible about it. On the other hand, condom involves two persons, and use before marriage were considered sin by the Lord and Bible. Hence, labelled HIV infected as 'sexually immoral' or 'adulterers' and destined to go to hell. These adversely affected prevention and had insufficient spiritual importance to be tackled by Church. Opposing the condom advice, a KTP (Youth group) leader said 'God' would not be happy discussing about it in Church and 'it is NGOs and governments job'. An elder was willing to support Mizoram State AIDS Control Society (MSACS) after praising MSACS for containing HIV infection in the state but for the numbers would have doubled. No clarity on the church stand on the HIV prevention in Presbyterian Church and there was no clear information on this from the Synod (the governing body). However, Church did not vocally opposed to condom, even it did not approve of advocating condom.

Condom and premarital sex

Advocating condom had both positive and negative views. Some youth leaders and elders felt, it will help in HIV prevention while, this was viewed as a 'double-edged sword' by increasing pre-marital sex among youth on the one side and it could sensitize unsafe sex will lead to HIV infection. Some youth leaders felt that prevention is better than cure and disagreed it would encourage pre-marital sex. Even many leaders felt it will lead to pre-marital sex due to high sexual promiscuity among youth, in spite of they had teachings on abstinence. According to a pastor, withholding information on Condom due to the fear of pre-marital sex is wrong. Stating an example, he reiterated, how God have been silent on the forbidden fruit in the Garden of Eden, but He specifically instructed them not to eat or else face the consequences, and it is one's duty to inform and rest is up to others to follow.

HIV and Church activities

In a Church during programs, people share communion cup, cups, glasses, other vessels and restrooms. Generally the church leaders were very apprehensive in sharing any of them with PLHIV. It was observed that there were instances where people shown urgency to clean items used by PLHIV before using them. If there was an option, many expressed would not share with PLHIV. They did not show it to PLHIV because they may hurt the feelings. This was in spite of the awareness that it does not spread by sharing them. The reason mentioned for not sharing included a possibility of the infected person having cuts or ulcers in mouth which are difficult to notice. With these assumptions many preferred sharing cups compared to restrooms.

Outcome of HIV prevention

Fear of pre-marital sex emerged from church leaders when discussed on condoms. According to a pastor, they talk about condom and clean needle syringe for HIV prevention, could be interpreted as a permission to use them. Further they felt, a strategy targeting a specific audience might encourage youth in experimenting with sexuality and repeated pre-marital sex.

Strategies for HIV prevention a Christian approach

Advocating HIV education from childhood was suggested as a Christian approach to the problem. Women leaders were doubtful about it as there were already many Church activities during nights that minimize the time spent with their children. An alternative in the form of Sunday schools on HIV to junior and intermediate departments along with once or twice a year program on the topic was suggested. Youth leaders preferred Church media such as, radio, television and booklets (KTP) to include HIV. For effective strategy, the core leaders of Presbyterian Church have to be sensitized on HIV. Suggestion on sending the revival speakers across the state to impart knowledge on HIV after their induction and refresher gatherings was made. Women leaders suggested once a year mass prayer for HIV. All emerged as they felt it was absent in Church programs. It was suggested to compile a list of PLHIV for the purpose of having discussions on prevention. If they are aware of the magnitude of the problem then there will be a sense of urgency. Some felt this could lead to discrimination. Leaders still believed the number of HIV infected were inflated for the purpose of getting funds.

Discussion

The proportion of Presbyterian Church leaders willing to advocate condom use was 30.4 percent, which is similar to Madagascar study reported that 39.4 percent for effective prevention for HIV (Rakotoniana et al., 2014). Christians in general continue to believe, The Bible describes sexual relations beyond the confine of marriage, is sinful act (Bottom, 2008). This was reflected as most Church leaders (70%) felt disobedience to Biblical teachings lead to HIV, in spite of their disagreement with HIV a punishment from God (Agadjanian and Sen, 2007). Many Church leaders (80%) mentioned homosexual deserve HIV (The Bible, Leviticus 20:10–21).

About three fourth of the Church leaders felt that the Church was not doing enough on HIV prevention. This is in confirmation with the study among Chinese immigrant religious institutions (Kang et al., 2013). Leaders' suggestion on need to talk about HIV prevention in Church services and programs found a positive impact in the United States among African American churches (Stewart, 2015). Lesser Church leaders were willing to advocate condom and syringe distribution among the youth members of the Church is similar to that of Thomas and Quin (1993) study. Sexual abstinence was advocated as the most

appropriate measure for HIV prevention in a Church setting is common with other studies (Agadjanian and Sen, 2007). Reasons cited for not advocating condom use were fear of increased sexual promiscuity, feeling condom is not 100 percent effective and is against Bible, are similar to Bootum (2008) study. Church leaders agreed condom will help in HIV prevention, but about three fourth still felt condom will encourage pre-marital sex. This finding is similar to that of Rankin et al. (2008) study. Only few Church leaders were not willing to support the needle-syringe exchange program which was also reported in another study (Vlahov et al., 2001). Discussion of focus groups revealed that it was easier to accept needle syringe exchange program as it involves one person and the Bible is not specific about it. In Mexico, Christian Church leaders were unable to accept harm reduction strategies on moral grounds (Philbin et al., 2009). Condom usage before marriage is a sin as per Lord says the Bible. Some blamed the Synod for not providing clear information on condom in HIV prevention. This is similar to that of findings of another study (Derose et al 2010). Studies have shown that knowing HIV infected person will help to develop and maintain HIV programs (Stewart, 2012). Present study shows with a few Church leaders knowing HIV infected did not affect involvement in congregants' education on HIV prevention. A study found that supportive Church environment was associated with the positive influence on healthy behaviours (Bogart et al., 2014). In contrary, our study suggests even after church involvement, it is not conducive for PLHIV as people were not willing to sit next to them.

Consequences of engaging in HIV prevention

There were concerns on information provided on HIV prevention would lead to increase in sexual experimentation among youth. This finding is similar to a study on sex and HIV related topics within religious confines causes the Church leaders and congregants feel uncomfortable and anticipate negative consequences out of that (Griffith et al., 2010). Further a study found, fear of pre-marital sex one of the main reasons for the Church leaders to be reluctant to share HIV, sex and condoms (Nunn et al., 2012). As suggested by a study it is important to meet and get acquainted with local church leaders and understand the churches' stand on it, so that public health can work together without affecting the faith while engage in HIV interventions (Cunningham et al., 2009).

Limitations

Since the study was done in an urban setting, the findings may not represent rural areas, and cannot be generalized to all Presbyterian Church leaders. Religious beliefs could have influenced the responses.

Conclusions

About one-third of the Presbyterian Church leaders expressed willingness to advocate condom use, and most of them were willing to advocate the needle-syringe exchange program. Abstinence before marriage has emerged as the most appropriate form of HIV prevention according to Church leaders. The leaders also felt their responsibilities related to HIV prevention with a hesitation to propagate condom use. Dilemma on approaches to preventions as a Church is palpable. Most of the Church leaders felt that the Church was not doing enough on HIV prevention and if an opportunity given to them, they will share their knowledge on HIV amongst the members.

Just a handful of Church leaders personally were in contact with a HIV infected person. In general they knew it did not make much of a difference when it comes to sharing information on HIV in the Church. Only a few Church leaders used their position to share about the topic in Church programs.

A Church is supposed to be a place of solace, inclusive, compassionate and not judgemental according to literature and the Bible. But at the same time the members were of a opinion, HIV positive were sinner and they deserve this for being disobedient to Biblical teachings. Personally knowing someone who is HIV positive does not seem to make much of a difference when it comes to being open about HIV prevention strategies. Misconceptions around HIV continue to exist irrespective of numerous awareness programs by the Mizoram Presbyterian Church. Evidenced by the findings that most Church leaders were not willing to share restrooms/toilets or sit beside HIV infected people during Church programs.

When it comes to prevention strategies, education on HIV issues from early childhood coupled with strong Biblical values was felt to be important. Incorporating them in Sunday school lessons and making use of the Church's media like print, radio and television. Strategically planned education programs for Church leaders and congregants which are sustainable, were felt to be crucial for an effective HIV prevention programs within the Church.

Declarations

Acknowledgements

The authors express their deep gratitude to the participants in this paper for volunteering to participate and share their experiences.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

References

- Arnold, R., Avants, S. & Margolin, A. et al. (2002). Patient attitudes concerning the inclusion of spirituality into addiction treatment. *Journal of Substance Abuse Treatment* 23(4): 319–326.
- Avants, S., Warburton, L. & Margolin, A. (2001). Spiritual and Religious Support in Recovery from Addiction Among HIV-Positive Injection Drug Users. *Journal of Psychoactive Drugs* 33(1): 39–45.
- Agadjanian, V. & Sen, S. (2007). Promises and Challenges of Faith-Based AIDS Care and Support in Mozambique. *Am J Public Health* 97(2): 362–366.
- Agha, S., Hutchinson, P. & Kusanthan, T. (2006). The effects of religious affiliation on sexual initiation and condom use in Zambia. *Journal of Adolescent Health* 38(5): 550–555.
- Allman, D., Adebajo, S. & Myers, T. et al. (2007). Challenges for the sexual health and social acceptance of men who have sex with men in Nigeria. *Culture, Health & Sexuality* 9(2): 153–168.
- Asekun-Olarinmoye, E., Fatiregun, A. & Asekun-Olarinmoye, et al. (2013). Perceptions and activities of religious leaders on the prevention of HIV/AIDS and care of people living with the HIV infection in Ibadan, Nigeria. *HIV* 121.
- Barouch, D. (2008). Challenges in the development of an HIV-1 vaccine. *Nature* 455(7213): 613–619.
- Baruth, M., Wilcox, S. & Laken, M. et al. (2008). Implementation of a Faith-Based Physical Activity Intervention: Insights from Church Health Directors. *Journal of Community Health* 33(5): 304–312.
- Berkley-Patton, J., Moore, E. & Hawes, S. et al. (2012). Factors Related to HIV Testing Among an African American Church-Affiliated Population. *AIDS Education and Prevention* 24(2): 148–162.
- Berkley-Patton, J., Thompson, C. & Martinez, D. et al. (2012). Examining Church Capacity to Develop and Disseminate a Religiously Appropriate HIV Tool Kit with African American Churches. *Journal of Urban Health* 90(3): 482–499.
- Berkman, A., Garcia, J. & Muñoz-Laboy, M. et al. (2005). A Critical Analysis of the Brazilian Response to HIV/AIDS: Lessons Learned for Controlling and Mitigating the Epidemic in Developing Countries. *Am J Public Health* 95(7): 1162–1172.
- Blank, M., Mahmood, M. & Fox, J. et al. (2002). Alternative Mental Health Services: The Role of the Black Church in the South. *Am J Public Health* 92(10): 1668–1672.
- Bogart, L., Derose, K. & Kanouse, D. et al. (2014). Correlates of HIV Testing among African American and Latino Church Congregants: The Role of HIV Stigmatizing Attitudes and Discussions about HIV. *Journal of Urban Health* 92(1): 93–107.
- Bottom, J. (2008). The Death of Protestant America: A Political Theory of the Protestant Mainline. First things. Available from: <http://www.firstthings.com/article/2008/08/001-the-death-of-protestant-america-a-political-theory-of-the-protestant-mainline>. Accessed 2 December 2015.
- CDC. (2011). AIDS: the Early Years and CDC's Response. Atlanta: Morbidity and Mortality Weekly Report (MMWR).
- Camlin, C. & Snow, R. (2006). Parental Investment, Club Membership, and Youth Sexual Risk Behavior in Cape Town. *Health Education & Behavior* 35(4): 522–540.
- Campbell, C., Foulis, C. & Maimane, S. et al. (2005). "I Have an Evil Child at My House": Stigma and HIV/AIDS Management in a South African Community. *Am J Public Health* 95(5): 808–815.
- Campbell, C., Skovdal, M. & Gibbs, A. (2010) Creating Social Spaces to Tackle AIDS-Related Stigma: Reviewing the Role of Church Groups in Sub-Saharan Africa. *AIDS Behav* 15(6): 1204–1219.
- Campbell, M., Hudson, M. & Resnicow, K. et al. (2007). Church-Based Health Promotion Interventions: Evidence and Lessons Learned. *Annu. Rev. Public Health* 28(1): 213–234.
- Catanzaro, A., Meador, K. & Koenig, H. et al. (2007). Congregational Health Ministries: A National Study of Pastors' Views. *Public Health Nursing* 24(1): 6–17.
- Charania, M., Crepaz, N. & Guenther-Gray, C. et al. (2010). Efficacy of Structural-Level Condom Distribution Interventions: A Meta-Analysis of U.S. and International Studies, 1998–2007. *AIDS and Behavior* 15(7): 1283–1297.
- Coates, T., Richter, L. & Caceres, C. (2008). Behavioural strategies to reduce HIV transmission: how to make them work better. *The Lancet* 372(9639): 669–684.
- Cohen, M., Shaw, G. & McMichael, A. et al. (2011). Acute HIV-1 Infection. *New England Journal of Medicine* 364(20): 1943–1954.
- Community Outbreak of HIV Infection Linked to Injection Drug Use of Oxycodone—Indiana, 2015. (2016). Cdc.gov, Available from: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6416a4.htm>. Accessed 22 May 2016.

- Crepaz, N., Marshall, K. & Aupont, L. et al. (2009). The Efficacy of HIV/STI Behavioral Interventions for African American Females in the United States: A Meta-Analysis. *American Journal of Public Health* 99(11): 2069–2078.
- Cunningham, S., Kerrigan, D. & McNeely, C. et al. (2009). The Role of Structure Versus Individual Agency in Churches' Responses to HIV/AIDS: A Case Study of Baltimore City Churches. *Journal of Religion and Health* 50(2): 407–421.
- Darbes, L., Crepaz, N. & Lyles, C. et al. (2008). The efficacy of behavioral interventions in reducing HIV risk behaviors and incident sexually transmitted diseases in heterosexual African Americans. *AIDS* 22(10): 1177–1194.
- DeHaven, M., Hunter, I. & Wilder, L. et al. (2004). Health Programs in Faith-Based Organizations: Are They Effective? *Am J Public Health* 94(6): 1030–1036.
- Derosé, K., Kenouse, D. & Patel, K. (2010). The Role of Faith-Based Organizations in HIV Prevention and Care in Central America. 1st ed. *RAND Health*, Available from: <http://www.rand.org/pubs/monographs/MG891.html>. Accessed 17 March 2016.
- Des Jarlais, D., Feelemyer, J. & Modi, S. et al. (2013). High coverage needle/syringe programs for people who inject drugs in low and middle income countries: a systematic review. *BMC Public Health* 13(1).
- DubeShomanah, M. (2003). HIV/AIDS and the curriculum. Geneva: WCC Publications. Available from: <http://www.wcc-coe.org/wcc/what/mission/dube-2.html>. Accessed 14 January 2016.
- Eriksson, E., Lindmark, G. & Haddad, B. et al. (2013). Young People, Sexuality, and HIV Prevention Within Christian Faith Communities in South Africa: A Cross-Sectional Survey. *Journal of Religion and Health* 53(6): 1662–1675.
- Geneva: World Council of Churches. (1997). Facing AIDS: The Challenge the Churches' Response. 1st ed., Available from: <http://wcc-coe.org/wcc/what/mission/ehaia-pdf/facing-aids-eng.pdf> Accessed 10 December 2015.
- Glanz, K., Rimer, B. & Viswanath, K. (2008). Health behavior. Available from: [http://www.sanjeshp.ir/phd/phd_91/Pages/References/health%20education%20and%20promotion/\[Karen_Glanz_Barbara_K_Rimer_K_Viswanath\]_Heal%28B](http://www.sanjeshp.ir/phd/phd_91/Pages/References/health%20education%20and%20promotion/[Karen_Glanz_Barbara_K_Rimer_K_Viswanath]_Heal%28B) Accessed 14 January 2016.
- Geneva: The Lutheran world federation. (2007). Grace, Care and Justice: A Handbook for HIV and AIDS work. Available from: http://www.lutheranworld.info/lwf/wp-content/uploads/2007/12/Grace_care_and-justice.pdf. Accessed 17 December 2015.
- Griffith, D., Pichon, L. & Campbell, B. et al. (2010). YOUR Blessed Health: A Faith-Based CBPR Approach to Addressing HIV/AIDS among African Americans. *AIDS Education and Prevention* 22(3): 203–217.
- Adams, J. (2015). HIV Outbreak in Indiana *N Engl J Med* 373(14):1379–1380.
- Hladik, F. & McElrath, M. (2008). Setting the stage: host invasion by HIV. *Nat Rev Immunol* 8(6): 447–457.
- Kang, E., Delzell, D. & Chin, J. et al. (2013). Influences of Stigma and HIV Transmission Knowledge on Member Support for Faith-Placed HIV Initiatives in Chinese Immigrant Buddhist and Protestant Religious Institutions in New York City. *AIDS Education and Prevention* 25(5): 445–456.
- Kurth, A., Celum, C. & Baeten, J. et al. (2010). Combination HIV Prevention: Significance, Challenges, and Opportunities. *Current HIV/AIDS Reports* 8(1) 62–72.
- Lagarde, E., Enel, C. & Seck, K. et al. (2000). Religion and protective behaviours towards AIDS in rural Senegal. *AIDS* 14(13): 2027–2033.
- Mahajan, A., Sayles, J. & Patel, V. et al. (2008). Stigma in the HIV/AIDS epidemic: a review of the literature and recommendations for the way forward. *AIDS* 22(Suppl 2): S57-S65.
- Mantell, J., Correale, J. & Adams-Skinner, J. et al. (2011). Conflicts between conservative Christian institutions and secular groups in sub-Saharan Africa: Ideological discourses on sexualities, reproduction and HIV/AIDS. *Global Public Health* 6(Sup2): S192-S209.
- McKoy, J. & Peterson, R. (2006). Reducing African-American women's sexual risk: can churches play a role? *Journal of National Medical Association* 98(7): 1151–1159, Available from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2569486/>. Accessed 19 March 2016.
- Mizoram Synod. (2011). Mizoramsynod.org, Available from: <http://mizoramsynod.org/index.php?pkh=thuthar&nid=1502>. Accessed 20 March 2016.
- MSACS. (2016). Mizoram State AIDS Control Society, Report. Available from: http://mizoramsacs.nic.in/newsite/hiv_status/latest_status.html. Accessed 19 February 2016.
- Murray, L., Garcia, J. & Muñoz-Laboy, M. et al. (2011). Strange bedfellows: The Catholic Church and Brazilian National AIDS Program in the response to HIV/AIDS in Brazil. *Social Science & Medicine* 72(6): 945–952.
- NACO. (2006). Strategy and implementation plan - National AIDS Control Programme Phase III [2007–2012] New Delhi, India
- NACO. (2014). HIV Sentinel Surveillance 2014–2015. New Delhi: NACO, Available from: http://www.naco.gov.in/upload/2016%20Data/SIMU/HIV_Sentinel_Surveillance_report.pdf. Accessed 27 February 2016.

- NACO. (2016). Naco.gov.in, Available from: http://naco.gov.in/NACO/National_AIDS_Control_Program/Services_for_Prevention/. Accessed 17 January 2016.
- NACO. (2016). Available from: http://naco.gov.in/sites/default/files/Annual%20Report%202015-16_NACO.pdf. Accessed 23 September 2016.
- Nunn, A., Cornwall, A. & Chute, N. et al. (2012). Keeping the Faith: African American Faith Leaders' Perspectives and Recommendations for Reducing Racial Disparities in HIV/AIDS Infection. *PLoS ONE* 7(5): e36172.
- O'Leary, D. (2014). The syndemic of AIDS and STD among MSM. *The Linacre Quarterly* 81(1): 12–37.
- Otolok – Tanga, E., Atuyambe, L. & Murphy, C. et al. (2007). Examining the actions of faith-based organizations and their influence on HIV/AIDS-related stigma: A case study of Uganda. *African Health Science* 7(1): 55–60.
- Philbin, M., Lozada, R. & Zúñiga, M. et al. (2008). A qualitative assessment of stakeholder perceptions and socio-cultural influences on the acceptability of harm reduction programs in Tijuana, Mexico. *Harm Reduction Journal* 5(1): 36.
- Philbin, M., Mantsios, A. & Lozada, R. et al. (2009). Exploring stakeholder perceptions of acceptability and feasibility of needle exchange programmes, syringe vending machines and safer injection facilities in Tijuana, Mexico. *International Journal of Drug Policy* 20(4): 329–335.
- Plattner, I.E., & Meiring, N. (2006). Living with HIV: the psychological relevance of meaning making. *AIDS Care* 18(3):241–245.
- Raboud, J. (2003). The Impact of Needle-Exchange Programs on the Spread of HIV Among Injection Drug Users: a Simulation Study. *Journal of Urban Health: Bulletin of the New York Academy of Medicine* 80(2): 302–320.
- Rakotoniana, J., Rakotomanga, J. & Barenes, H. (2014). Can Churches Play a Role in Combating the HIV/AIDS Epidemic? A Study of the Attitudes of Christian Religious Leaders in Madagascar. *PLoS ONE* 9(5): e97131.
- Rankin, S., Lindgren, T. & Kools, S. et al. (2008). The Condom Divide: Disenfranchisement of Malawi Women by Church and State. *Journal of Obstetric, Gynecologic & Neonatal Nursing* 37(5): 596–606.
- Richards, D. (1986). *Sex, Drugs, Death, and the Law: An Essay on Human Rights and Overcriminalization*. Rowman & Littlefield. Available from: <https://books.google.co.in/books?id=Mwp9qN4toC&dq=sex+drugs+and+the+law+st.augustine&q=st.augustine#v=snippet&q=st.augustine&f=false>. Accessed 17 January 2016.
- Richman, D., Margolis, D. & Delaney, M. et al. (2009). The Challenge of Finding a Cure for HIV Infection. *Science* 323(5919): 1304–1307.
- Roman Isler, M., Eng, E. & Maman, S. et al. (2014). Public health and church-based constructions of HIV prevention: black Baptist perspective. *Health Education Research* 29(3): 470–484.
- Santmyre, A. & Jamison, M. (2006). Educating African Pastors on Mother-to-Child Transmission of HIV/AIDS. *Journal of Nursing Scholarship* 38(4): 321–327.
- Scott, N., Gabriel, S. & Sheppard, V. et al. (2015). Responding to a measles outbreak in a Pacific island community in western Sydney: community interviews led to church-based immunization clinics. *Western Pacific Surveillance and Response Journal* 6(2): 51–57.
- Simoes, E., John, J. & Solomon, S. (1987). evidence for HTLV-III infection in prostitutes in Tamil Nadu (India). *Indian Journal of Medical Research* 85: 335-8. Available from: http://icmr.nic.in/ijmr/2012/October/Most_cited1.pdf. Accessed 7 March 2016.
- Smith, J., Simmons, E. & Mayer, K. (2005). HIV/AIDS and the Black Church: what are the barriers to prevention services? *Journal of National Medical Association* 97(12): 1682–1685. Available from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2640746/>. Accessed 8 April 2016.
- Stewart, J. (2014). Implementation of Evidence-Based HIV Interventions for Young Adult African American Women in Church Settings. *Journal of Obstetric, Gynecologic & Neonatal Nursing* 43(5): 655–663
- Stewart, J. (2015). A Multi-Level Approach for Promoting HIV Testing Within African American Church Settings. *AIDS Patient Care and STDs* 29(2): 69–76.
- Tanga, E., Atuyambe, L. & Murphy, C. (2007). Examining the actions of faith-based organizations and their influence on HIV/AIDS-related stigma: A case study of Uganda. *African health science* 7(1): 55–60.
- Thomas, S., & Quinn, S. (1993). The Burdens of Race and History on Black Americans' Attitudes toward Needle Exchange Policy to Prevent HIV Disease. *Journal of Public Health Policy* 14(3): 320.
- The Bible, New World Translation. (1961). Pennsylvania: Watch Tower Bible and Tract Society. Available from: <https://www.jw.org/en/publications/bible/nwt/books/>. Accessed 20 February 2016.
- Trinitapoli, J., Ellison, C. & Boardman, J. (2009). US religious congregations and the sponsorship of health-related programs. *Social Science & Medicine* 68(12): 2231–2239.
- UNAIDS. (2014). The Gap Report. Geneva: UNAIDS. Available from: http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf. Accessed 19

February 2016.

UNAIDS. (2016). Available from: http://www.unaids.org/sites/default/files/media_asset/JC2007_Combination_Prevention_paper_en_0.pdf. Accessed 17 July 2016.

Vlahov D, Des Jarlais D & Goosby E et al. (2001). Needle Exchange Programs for the Prevention of Human Immunodeficiency Virus Infection: Epidemiology and Policy. *American Journal of Epidemiology* 154(12): S70-S77.

World Council of Churches. (2016). Oikoumene.org, Available from: <https://www.oikoumene.org/en/resources/documents/wcc-programmes/justice-diakonia-and-responsibility-for-creation/ehaia/world-council-of-churches-statements-and-studies/1997-facing-aids-the-challenge-the-churches-response/chapter-6-pastoral-care-and-healing-community>. Accessed 22 May 2016.

Figures

Figure 1

Sample Size